WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE ATTACHMENT (PA/SAA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Substance Abuse Attachment (PA/SAA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Performing Provider
Enter the name and credentials of the therapist who will be providing treatment.

Element 5 — Performing Provider's Medicaid Provider Number (not required)
Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider
Enter the performing provider's telephone number, including area code.

Element 7 — Name — Referring / Prescribing Provider
Enter the name of the provider referring/prescribing treatment.

Element 8 — Referring / Prescribing Provider's Medicaid Provider Number
Enter the referring/prescribing provider's eight-digit provider number, if available. The remaining portion of this attachment is to be used to document the medical necessity for the service requested.

SECTION III — TYPE OF TREATMENT REQUESTED

Element 9
Designate the type of treatment requested (e.g., primary intensive outpatient treatment, aftercare/follow-up service, or affected family member/codependency treatment). Identify the types of sessions, duration, and schedule. The total hours must match the quantities indicated in Element 20 of the PA/RF.

If a certified psychotherapist is requesting specific psychotherapy services for the substance abuse-affected recipient that are not represented by the categories of treatment listed, complete the Prior Authorization/Psychotherapy Attachment (PA/PSYA).

SECTION IV — DOCUMENTATION

Element 10
Indicate if the recipient was in primary substance abuse treatment in the last 12 months. If "yes," provide dates, problem(s), outcome, and provider of service.

Element 11
Enter the dates of diagnostic evaluation(s) or medical examination(s) in MM/DD/YY format.

Element 12
Specify diagnostic procedures employed.

Element 13
Provide current primary and secondary diagnosis (refer to the current Diagnostic and Statistical Manual of Mental Disorders) codes and descriptions.

Element 14
Describe the recipient's current clinical problems and relevant history. Include substance abuse history.

Element 15
Describe the recipient's family situation. Describe how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

Element 16
Provide a detailed description of treatment objectives and goals.

Element 17
Describe expected outcome of treatment (include use of self-help groups if appropriate).

SECTION V — SIGNATURES

Element 18 — Signature — Recipient or Representative (optional)
Signature of the recipient or representative indicates the recipient has read the attached request for PA of substance abuse and agrees that it will be sent to Wisconsin Medicaid for review. The recipient's signature is optional.

Element 19 — Date Signed
Enter the month, day, and year the PA/SAA is signed (in MM/DD/YY format) by the recipient or representative.

Element 20 — Relationship (if representative)
Include representative's relationship to recipient, if applicable, when a representative signs.

Element 21 — Signature — Performing Provider
Wisconsin Medicaid requires the performing provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 22 — Date Signed
Enter the month, day, and year the PA/SAA is signed (in MM/DD/YY format) by the performing provider.

Element 23 — Discipline of Performing Provider
Enter the discipline of the performing provider.

Element 24 — Performing Provider's Medicaid Provider Number
Enter the performing provider's Medicaid provider number.

Element 25 — Signature — Supervising Provider
Signature required only if the performing provider is not a physician or psychologist.

Element 26 — Date Signed
Enter the month, day, and year the PA/SAA was signed (in MM/DD/YY format) by the supervising provider, if applicable.

Other Information

- Providers may attach copies of assessments, treatment summaries, treatment plans, or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.

- Attach a copy of the signed and dated prescription for substance abuse services (unless a physician is the performing provider). The initial prescription must be signed and dated within three months of receipt by Wisconsin Medicaid. Subsequent prescriptions must be dated within twelve months of receipt by Wisconsin Medicaid.

- The attachment must be signed and dated by the provider requesting/providing the service.